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Attorneys for Complainant

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: NORMAN KING BEALS, M.D. 22706 Aspen St., Suite 501 El Toro, California 92630 Physician's and Surgeon's Certificate No. G 6248, Respondent.	No. D-4109 STIPULATION IN SETTLEMENT AND DECISION

IT IS HEREBY STIPULATED AND AGREED by and between the parties in the above-entitled action as follows:

1. Kenneth Wagstaff, complainant, is the Executive Officer of the Medical Board of California (formerly the Board of Medical Quality Assurance), Department of Consumer Affairs State of California (hereinafter the "Board"), and is represented in these proceedings by John K. Van De Kamp, Attorney General of the State of California, by and through Deputy Attorney General Susan Fitzgerald.

2. Norman King Neals, M.D., (hereafter "respondent"), is represented in all matters pending regarding this administrative proceeding by Christopher Marshall, Esq. of Bonne, Jones, Bridges, Mueller, O'Keefe & Hunt, 3699 Wilshire Blvd., 10th Floor, Los Angeles, California 90010-2719. Respondent has counseled with his attorney regarding this stipulation, its terms and effects, and has carefully read and fully understands its contents.

3. At all times mentioned herein, respondent was [illegible] issued by the Board under Physician's & Surgeon's Certificate No. G 6248. On or about November 13, 1989, complainant, in his official capacity as Executive Officer of the Board, filed Accusation No. D-4109, (hereinafter the "Accusation"), against respondent.

4. On or about November 16, 1989, respondent was served with Accusation No. D-4109, together with all other statutorily required documents, at his address of record on file with the Board, 23700 Aspan Street, Suite 501, El Toro, California 92630. Respondent timely filed his Notice of Defense.

5. Respondent has carefully read and fully understands the charges and allegations contained in Accusation No. D-4109. Respondent is fully aware of his rights to a hearing on the charges and allegations contained in the Accusation, his right to reconsideration, appeal, and any and all other rights which may be accorded him pursuant to the California Administrative Procedure Act and Code of Civil Procedure. Respondent hereby freely, voluntarily and intelligently waives his rights to a

hearing, reconsideration, appeal, and any and all other rights which may be accorded him pursuant to the California Administrative Procedure Act and Code of Civil Procedure with regard to Accusation No. D-4109.

6. Respondent, desiring to avoid the expense and emotional distress attendant to a full evidentiary hearing upon Accusation No. D-4109, and for the purpose of this proceeding and any subsequent proceedings between the parties only, and not for any other proceedings such as criminal or civil actions, if any, filed against Respondent, hereby admits the truth and accuracy of each and every allegation against him contained in Accusation No. D-4109, and that cause for disciplining exists against his license to practice medicine in accordance with Accusation No. D-4109.

7. In consideration for the foregoing stipulations, admissions and recitals, the Board, upon formal acceptance of Respondent's formal stipulation to revocation herein, agrees not to refile the Accusation of November 13, 1989 against Respondent in the future nor investigate or take any further disciplinary action for the acts or omissions of Respondent alleged in the Accusation of November 13, 1989. The Board agrees not to commence any other disciplinary action against Respondent for any acts or omissions of Respondent known to the Board or its employees or investigators up to and including the effective date of decision in this case. The Board also agrees it will not further investigate acts or omissions of Respondent known to the Board up to the effective date of this decision. The Board further agrees that except for the offenses for which Respondent

is being disciplined in Accusation No. D-4109 it will not raise at any reinstatement hearing any acts or omissions of Respondent known to the Board up to and including the effective date of decision in this case.

WHEREFORE, IT IS STIPULATED that the Board may, without further notice or formal proceeding, issue and enter the following decision:

A. Physician's & Surgeon's Certificate No. G-6248 issued to Respondent Norman King Beals, M.D. is hereby revoked.

B. Respondent is aware of California Business & Professions Code section 2307 which provides, among other things, that a person whose certificate has been revoked may petition the Division of Medical Quality for reinstatement after not less than one year has elapsed from the effective date of the decision ordering such disciplinary action.

C. This Stipulation in settlement shall be subject to the approval of the Medical Board of California, Department of Consumer Affairs, State of California. If the Board fails to approve this Stipulation in settlement, it shall be of no force and effect for either party.

I CONCUR IN THIS STIPULATION IN SETTLEMENT.

Dated: ~~February~~ March 2, 1990

SUSAN FITZGERALD
Deputy Attorney General
Attorney for Complainant

I CONCUR IN THIS STIPULATION IN SETTLEMENT.

Dated: February 28, 1990

CHRISTOPHER MARSHALL, ESQ.
Attorney for Respondent Beals

ACKNOWLEDGEMENT

I, Norman King Beals, M.D., have read the above stipulation and counseled with my attorney about it. I enter into the stipulation freely, voluntarily, intelligently, and with full knowledge of its force and effect.

Dated: March 1, 1990

NORMAN KING BEALS, M.D.
Respondent

O R D E R

The stipulated revocation of Physician's & Surgeon's Certificate No. G 6248, by respondent Norman King Beals, M.D., is hereby accepted by the Medical Board of California, Department of Consumer Affairs, State of California.

This decision shall become effective on the 21st day of March, 1990.

SO ORDERED this 21st day of March, 1990.

Theresa Claassen

DIVISION OF MEDICAL QUALITY
Department of Consumer Affairs
State of California

THERESA CLAASSEN - Secretary/Treasurer

Redacted

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BEFORE THE

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. D-4109
NORMAN K. BEALS, M.D. 22706 Aspan Street, Suite 501 El Toro, California 92630 Physician's & Surgeon's Certificate No. G6248, Respondent.	ACCUSATION

COMES NOW Complainant, Kenneth Wagstaff, who as cause for disciplinary action, alleges:

1. Complainant is the Executive Officer of the California State Board of Medical Quality Assurance ("Board") and makes and files this accusation solely in his official capacity.

LICENSE STATUS

2. On or about August 30, 1970, the Board issued Physician's & Surgeon's Certificate No. G6248 to Norman K. Beals,

M.D. ("respondent"), and at all times relevant herein, said license was and remains paid and current. Respondent is a supervisor of a physician assistant. That license, #SA10588, has been, however, in delinquent status since May 31, 1986.

PRIOR LICENSE DISCIPLINE

3. On April 5, 1973, an Accusation was filed against Dr. Beals and on April 11, 1975, a Decision became effective imposing one year of probation. This action was based on the respondent's employment of unlicensed persons whom he aided and abetted in the unlicensed practice of medicine.

STATUTES

4. This accusation references the following sections of the California Business and Professions Code ("Code"):

A. Code section 2234 provides that the Board may discipline any licensee charged with unprofessional conduct, which includes, but is not limited to, the following:

"(b) gross negligence

"(c) repeated negligent acts

"(d) incompetence.

"(e) commission of any dishonest or corrupt act substantially related to the qualifications, functions or duties of a physician surgeon."

B. Code section 725 provides, in pertinent part, as follows:

"Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or

repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the * * * community of licensees is unprofessional conduct for a physician and surgeon ...."

C. Section 4211 of the Code provides, in pertinent part, that a "dangerous drug" means any drug unsafe for self-medication ... and includes ... any drug requiring a prescription in order to be dispensed.

D. Code section 2242 provides that prescribing, dispensing, or furnishing dangerous drugs as defined in section 4211 without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

E. Code section 17500 provides, in pertinent part, as follows:

"It is unlawful for any person ... with intent directly or indirectly ... to perform services, professional or otherwise, or anything of any nature whatsoever or to induce the public to enter into any obligation relating thereto, to make or disseminate or cause to be made or disseminated before the public in this state, ... , in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatever, any statement, concerning such ... services, professional or otherwise, or concerning any circumstance or matter of fact connected with the proposed performance or disposition thereof, which is

untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading ...."

F. Health and Safety Code section 11210, a statute of this state regulating dangerous drugs or controlled substances, provides, as relevant hereto, that a physician and surgeon shall prescribe controlled substances only in such quantity and for such length of time as are reasonably necessary.

G. Code section 2238 provides, as relevant hereto, that a violation of any of the statutes of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

H. All of the following require a prescription in order to be administered or dispensed, and are classified as dangerous drugs pursuant to Code section 4211:

1). estrone - an estrogenic female hormone.

2). estradiol - a crystalline steroid possessing estrogenic properties.

3). Estrace - a brand name for micronized estradiol.

4). Depo Provera - a brand name for medroxyprogesterone acetate, a derivative of progesterone.

5). progesterone - a steroid hormone.

6). Premarin - a brand name for conjugated estrogen.

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7). Estraderm - a brand name for a transdermal delivery system for estradiol.

8). testosterone - a steroid male hormone.

9). atropine sulfate - the salt of an alkaloid obtained from belladonna.

10). Depo-Medrol - a brand name for methylprednisolone acetate, an anti-inflammatory glucocorticoid.

11). gamma globulin - a human blood protein.

12). L-Thyroxine - an amino acid obtained from the thyroid gland.

13). Synthroid - a brand name for levothyroxine sodium.

14). Maxzide - a brand name for triamterene with hydrochlorothiazide, a potassium conserving diuretic.

15). Lasix - a brand name for furosemide, a potent diuretic.

16). potassium chloride - potassium in crystalline salt form.

17). K-lyte - a brand name for potassium as bicarbonate and citrate.

18). Hyosophen - a brand name for belladonna and phenobarbital.

19). Vistaril - a brand name for hydroxyzine hydrochloride.

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20). Xanax - a brand name for alprazolam. Zanax is also a Schedule IV controlled substance under California Health and Safety Code section 11057.

FACTS CONCERNING PATIENTS

5. Respondent is subject to disciplinary action pursuant to the above-cited Code sections, as more particularly alleged below:

A. Patient B[redacted] M[redacted]

1. On June 17, 1988, B[redacted] M[redacted] became a patient of respondent after receiving a pamphlet from respondent's clinic, HRT-Women's Health Care Center, in El Toro, California.

2. B[redacted] M[redacted] was 56 years old at the time with history of a hysterectomy and was being treated with Estroderm patches and thyroid pills. She told Dr. Beals of this medical background.

3. At no time during her visit to respondent on June 17, 1988, or at any other time during his treatment of her, did respondent or any employee of respondent take a complete and adequate medical history of Mrs. M[redacted]

4. At no time during her visit to respondent on June 17, 1988 or at any other time during his treatment of her, did respondent give Mrs. M[redacted] a physical examination.

5. On her visit to respondent of June 17, 1988, Mrs. M[redacted] was seen and treated by a female employee of respondent. Respondent never saw her on that date.

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6. At no time on June 17, 1988 or at any time during his treatment of Mrs. M[redacted] did respondent or any of his employees discuss the potential risks and side-effects from hormone replacement therapy ("HRT").

7. On June 17, 1988, without adequate medical history, physical examination or any diagnostic laboratory tests, respondent, through his employees, started giving Mrs. M[redacted] injections of hormones and prescriptions for more hormones plus other dangerous drugs.

8. On June 17, 1988, respondent, through his employees, ordered an excessive number of laboratory tests for Mrs. M[redacted] This laboratory work was done at HRT Lab, Inc., which corporation bears the same address of 22706 Aspan Street, Suite 501, El Toro, California as respondent's "clinic". Respondent was and is the director of that laboratory.

9. During his treatment of her, respondent administered and prescribed an excessive amount of hormones to B[redacted] M[redacted]

10. During his treatment of Mrs. M[redacted] respondent administered, dispensed or prescribed K-lyte, Lasix, and Depo-medrol with no adequate medical indication to do so.

11. On June 24, 1988 and July 1, 1988 respondent gave Mrs. M[redacted] injections of gamma globulin with no adequate medical indication to do so.

12. On July 1, and 2, 1988 Mrs. M[redacted] informed respondent of possible side effects from the drugs respondent was

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giving her, including a severe adverse reaction the night of July 1, 1988.

13. When Mrs. M[redacted] tried to inform respondent on the morning of July 2, 1988 of her problems the night before, respondent could not be contacted by his office or answering service and no other doctor was covering for him.

14. When respondent finally contacted Mrs. M[redacted] at approximately 5:30 p.m. on July 2, 1988, she told him of severe shakes, chills, nausea, and heart pounding, to which respondent advised that her body had just gone through a trauma from a virus which she had obviously thrown off and that if she had another reaction she should go to a hospital and get a gamma globulin shot.

B. Patient L[redacted] W[redacted]

1. On October 14, 1987, L[redacted] W[redacted] became a patient of respondent at the HRT-Women's Health Care Center in El Toro, California.

2. Ms. W[redacted] was 38 years old at the time and went to respondent for treatment of premenstrual syndrome ("PMS").

3. At no time during her visit to respondent on October 14, 1987, or at any other time during his treatment of her, did respondent or any employee of respondent take a complete and adequate medical history of L[redacted] W[redacted].

4. At no time during her visit to respondent on October 14, 1987 or at any other time during his treatment of her, did respondent give L[redacted] W[redacted] a physical examination.

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5. On her visit to respondent of October 14, 1987, Ms. W[redacted] was seen and treated by a female employee of respondent. Respondent never saw her on that date.

6. At no time on October 14, 1987 or at any time during his treatment of Ms. W[redacted] did respondent or any of his employees discuss the potential risks and side-effects from HRT.

7. On October 14, 1987, without adequate medical history, physical examination or any diagnostic laboratory tests, respondent and/or his employee, started giving Ms. W[redacted] injections of hormones and prescriptions for more hormones plus other dangerous drugs.

8. On October 14, 1987, respondent ordered an excessive number of laboratory tests for L[redacted] W., which lab tests were done at HRT Lab, Inc.

9. During his treatment of her, respondent administered and prescribed an excessive amount of hormones to L[redacted] W[redacted].

10. During his treatment of Ms. W[redacted] respondent administered, dispensed or prescribed Maxzide and K-lyte with no adequate medical indication to do so.

11. Respondent knew or should have known that the combination of Maxzide and K-lyte which he prescribed, administered or dispensed to L[redacted] W[redacted] created potential serious harm to his patient from excessive potassium.

12. On October 21, 1987, respondent prescribed Xanax for L[redacted] W[redacted] with no adequate medical indication to do so or without adequate recordation of an adequate medical indication.

13. On October 21, 1987 respondent excessively prescribed 40, 1 mg. tablets of Xanax for L[redacted] W[redacted].

14. On October 14, 1987, respondent prescribed, administered or dispensed Synthroid and/or L-Thyroxine to L[redacted] W[redacted] with no medical indication to do so.

15. Respondent knew or should have known by October 21, 1987 that the laboratory tests of Ms. W[redacted] showed normal and/or non-diagnostic thyroid function. Respondent, however, continued his patient on Synthroid and/or L-Thyroxine after that date.

16. Respondent diagnosed L[redacted] W[redacted] as hypoglycemic with no medical indication for that diagnosis. In fact, she was not hypoglycemic.

17. Respondent diagnosed L[redacted] W[redacted] as hypoestrogenemic with no medical indication for that diagnosis.

18. On October 17, 1987 respondent administered atropine to Ms. W[redacted] with no adequate medical indication to do so or without recordation of adequate medical indication.

19. On or about October 28, 1987 and again on November 4, 1987 Ms. W[redacted] reported possible side effects from the drugs respondent was giving her. She was able to speak only to a female employee of respondent on those occasions and despite severe cramping, swollen and tender breasts, and worsening PMS L[redacted] W[redacted] was continued on hormone treatments by injection and orally.

20. On November 12, 1987, despite complaint of feeling very ill, respondent advised Ms. W[redacted] to <u>increase</u> her dosage of

progesterone to three times per week and to take it every day if she had no relief. I W continued to feel increasingly worse until she decided to stop all medications prescribed or administered by respondent.

C. Patient M S

1. On October 12, 1987 M S became a patient of respondent with complaints of fatigue, a craving for sweets, persistent pain in her left abdominal area, and PMS.

2. Ms. S was 27 years old at the time, with a history of mitral valve prolapse and medication with 40 mg. Inderal three times a day for eight years, all of which she told respondent on her first visit.

3. At no time during her visit to respondent on October 12, 1987, or at any other time during his treatment of her, did respondent or any employee of respondent take a complete and adequate medical history of Ms. S.

4. At no time during her visit to respondent on October 12, 1987, or at any other time during his treatment of her, did respondent give Ms. S a physical examination.

5. At no time on October 12, 1987, or at any time during his treatment of M S, did respondent or any of his employees discuss the potential risks and side-effects from HRT.

6. On October 12, 1987, without adequate medical history, physical examination or any diagnostic laboratory tests, respondent and/or his employee started giving M S injections of hormones and a further hormone prescription for

0.5 mg. Premarin tablets, which respondent told her to take once or twice a day or up to six a day, if necessary.

7. On October 12, 1987, respondent ordered an excessive number of laboratory tests for Ms. S[redacted]. The lab tests were done at HRT Lab, Inc.

8. During his treatment of her, respondent administered and prescribed an excessive amount of hormones to Ms. S[redacted].

9. Respondent diagnosed Ms. S[redacted] as hypoestrogenemic with no medical indication for this diagnosis. In fact, M[redacted] S[redacted] was not hypoestrogenemic.

10. Respondent also diagnosed Ms. S[redacted] as suffering from both adrenal failure and hormone imbalance with no medical indication for this diagnosis. In fact, M[redacted] S[redacted] did not have adrenal failure or a hormone imbalance.

11. On or about October 19, 1987, Ms. S[redacted] reported to respondent that she had the shakes, disorientation/panic attacks, and what felt like adrenalin rushes. Respondent advised her she had too much testosterone in her system when, in fact, respondent knew or should have known that the laboratory results showed a non-diagnostic and/or normal level of testosterone as well as normal levels of other hormones. Respondent then <u>increased</u> Ms. S[redacted]' injections of estrone and estradiol.

12. Both during office visits to respondent after October 19, 1987 and in telephone calls to respondent's office in between office visits, Ms. S[redacted] continued to complain of

shakiness, heart palpitations and panic attacks. These complaints were not recorded in her medical records.

D. Patient C[redacted] F[redacted]

1. On February 22, 1989, C[redacted] F[redacted] became a patient of respondent with complaints of often feeling cold and tired and lack of energy. She thought she might be anemic or have low thyroid.

2. At the time of her visit to respondent, Ms. F[redacted] was 35 years old, engaged to be married, and desired to have children from that marriage.

3. At no time during her office visit to respondent on February 22, 1989 or on her next office visit approximately a week later did respondent ever give Ms. F[redacted] a physical examination. In fact, on February 22, 1989 respondent told Ms. F[redacted] that her symptoms were typical of PMS and that her only relief would be through his treatment with hormones.

4. Respondent further told Ms. F[redacted] on February 22, 1989, that she would have to have an injection once a week for the rest of her life and would have to take oral diuretics, gamma globulin, B-12, and Depo-provera. Respondent further told Ms. F[redacted] on February 22, 1989 that if she did not start his hormone treatment program that she probably would not have children or, if she did, they would be malformed. All of these statements by respondent seriously upset and scared Ms. F[redacted].

5. At no time on February 22, 1989 or at any time thereafter did respondent or any of his employees discuss the potential risks and side-effects of HRT.

6. On February 22, 1989 respondent ordered an excessive number of laboratory tests for Ms. F[redacted]. The lab tests were done at HRT Lab, Inc.

7. On Ms. F[redacted]'s return visit to respondent for her laboratory results, approximately one week after February 22, 1989, respondent told Ms. F[redacted] her estrogen level was dangerously low, she was about to fall off a cliff, and again told her that without his program she probably would not get pregnant or probably would have deformed children.

8. Respondent also told Ms. F[redacted] at this time that she had herpes when, in truth and fact, she does not.

9. Respondent's medication of Ms. F[redacted] altered her expected menstrual period. When her period started she noted a large blood clot and became concerned about a possible miscarriage. She contacted respondent (by telephone) who refused to examine the clot, got very angry at Ms. F[redacted] for discontinuing his program and hung up on her.

E. PATIENT L[redacted] H[redacted]

1. On March 2, 1988, L[redacted] H[redacted] became a patient of respondent at HRT-Women's Health Care Center in El Toro, California.

2. Ms. H[redacted] was 33 years old at the time, is 5'8" tall and weighed 121 lbs. She went to respondent with complaints of indigestion with gas and excessive hair loss. Ms. H[redacted] had no children but desired to have children in the future.

3. At no time during her visit to respondent on March 2, 1988, or at any time during his treatment of her, did

respondent or any employee of respondent take a complete and adequate medical history of L[redacted] H[redacted].

4. At no time during her visit to respondent on March 2, 1988, or at any other time during his treatment of her, did respondent or any other qualified medical doctor give L[redacted] H[redacted] an adequate physical examination.

5. At no time on March 2, 1988 or at any time during his treatment of Ms. H[redacted] did respondent or any of his employees discuss the potential risks and side-effects from HRT.

6. On March 2, 1988, without adequate medical history, adequate physical examination or any diagnostic laboratory test, respondent and/or his employee started giving L[redacted] H[redacted], among other things, injections of hormones and prescriptions for Premarin, thyroid and Lasix.

7. On March 10, 1988, with no medical indication to do so and/or no adequate recordation of medical indication, respondent diagnosed Ms. H[redacted] as having cervicitis, depression, PMS and ovarian failure.

8. On or about March 20,1988, Ms. H[redacted] broke out in a rash all over her body. She went to see respondent that day, who continued her on the hormone injections and previously prescribed medications and gave her, additionally, at least a gamma globulin injection.

9. On April 18, 1988 Ms. H[redacted] again complained of a rash on her legs, arms and chest. Respondent continued the hormone injections and the previously prescribed oral

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medications and added oral progesterone and Zantac to his prescriptions for her.

F. PATIENT G[redacted] H[redacted]

1. On May 2, 1989, G[redacted] H[redacted] became a patient of respondent. Ms. H[redacted] had had a hysterectomy about two years before May of 1989 and felt she was basically well, but suffering some mood swings.

2. At on time during her visit to respondent on May 2, 1989, or at any time during his treatment of her did respondent or any employee of his take a complete and adequate medical history.

3. At no time during her visit to respondent on May 2, 1989 or at any other time during his treatment of her, did respondent give Ms. H[redacted] an adequate physical examination.

4. On the May 2, 1989 visit, respondent, without waiting for the results of laboratory tests, told Ms. H[redacted] that he could tell she was "definitely depleted", and that there were only 24 other doctors in the United States doing this kind of hormone replacement therapy.

5. On May 2, 1989, without adequate medical history, physical examination or any diagnostic laboratory tests, respondent started giving Ms. H[redacted] injections of hormones, Vitamin B, and an anti-inflammatory drug for arthritis.

6. At no time on May 2, 1989 or at any time during his treatment of her did respondent or any of his employees discuss the potential risks and side-effects from HRT.

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7. Shortly after beginning HRT with respondent, Ms. H[redacted] started gaining weight. Respondent gave her increasing dosages of diuretics and Ms. H[redacted] did not urinate normally during the entire time she was treated by respondent.

8. Approximately one month after starting treatment with respondent, Ms. H[redacted] developed what she thought looked like a blood clot in her leg. She requested to see respondent about her leg during her weekly visit and was told by one of respondent's employees that Dr. Beals was too busy to see her, that the leg looked like phlebitis and that she should stay off her feet. Respondent diagnosed phlebitis the next week, and thereafter attempted to have Ms. H[redacted] sign a form saying that if she developed, among other things, heart disease or blood clots that she would go to another physician. An employee of respondent told Ms. H[redacted] that if she did not sign the form that respondent would not give her HRT.

9. On or about August 8, 1989 and again approximately one or two weeks later, Ms. H[redacted] complained to respondent that she was feeling really sick, weak, tired and that she had a severe rash. Respondent drew blood for more blood tests during the mid-August office visit of Ms. H[redacted]. She was told that she owed another $710 for that work.

10. On or about September 4, 1989, Ms. H[redacted] called respondent to tell him that she still felt very ill, was vomiting, still had the rash, that her leg hurt and that she needed an appointment. Ms. H[redacted] also wanted the results of her most recent blood tests. She was told by respondent's

employee that the blood had never been sent to the laboratory because of Ms. H[redacted]'s unpaid bill and that respondent could not see her unless she made larger payments.

11. After Ms. H[redacted]'s insurance company paid respondent, an employee of respondent called Ms. H[redacted] and told her that respondent could see her again.

12. On or about September 12, 1989, Ms. H[redacted] returned to see respondent to question him about the cancelled laboratory work and his treatment of her. Dr. Beals got angry and told his patient that he did not have to carry anyone and that he had poor judgment to accept her as a patient. When Ms. H[redacted] tried to obtain her medical records from respondent as she left his office that day, she was told that she could not have them until her bill was paid in full.

13. On or about September 18, 1989, Ms. H[redacted] went back to her regular physician who she had seen one week earlier. He stated to her that the blood tests he ran on her showed that she had developed hepatitis due to an overabundance of hormones to the liver.

VIOLATIONS CONCERNING PATIENTS

6. Grounds exist for revocation or other discipline of respondent's license to practice medicine in that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by failing to take an adequate medical history before starting treatment, as alleged in paragraphs 5(A)(3) regarding B[redacted] M[redacted], 5(B)(3) regarding L[redacted] W[redacted], 5(C)(3) regarding M[redacted] S[redacted], 5(E)(3)

regarding L[redacted] H[redacted], and 5(E)(2) regarding G[redacted] H[redacted], which violates Code section 2234.

7. Further grounds exist for revocation or other discipline of respondent's license in that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by failing to conduct an adequate physical examination before starting treatment, as alleged in paragraphs 5(A)(4) regarding B[redacted] M[redacted], 5(B)(4) regarding L[redacted] W[redacted], 5(C)(4) regarding M[redacted] S[redacted], 5(D)(3) regarding C[redacted] R[redacted], 5(E)(4) regarding L[redacted] H[redacted] and 5(F)(3) regarding G[redacted] H[redacted], which violates Code section 2234.

8. Further grounds exist for revocation or other discipline of respondent's license in that respondent prescribed, dispensed, or furnished dangerous drugs without a good faith prior examination and medical indication therefor, as alleged in paragraphs 5(A)(7), (10), and (11) regarding B[redacted] M[redacted], 5(B)(7), (10), (12), (14), (15), (18), and (20) regarding L[redacted] W[redacted], 5(C)(6) and (11) regarding M[redacted] S[redacted], 5(E)(6) regarding L[redacted] H[redacted] and 5(F)(5) regarding G[redacted] H[redacted], which violates Code section 2242.

9. Further grounds exist for revocation or other discipline of respondent's license in that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by failing to discuss at any time the potential risks and side-effects from HRT, as alleged in paragraphs 5(A)(6) regarding B[redacted] M[redacted], 5((B)(6) regarding L[redacted] W[redacted], 5(C)(5) regarding M[redacted] S[redacted], 5(D)(5) regarding

C[redacted], 5(E)(5) regarding L[redacted] H[redacted], and 5(F)(6) regarding G[redacted] H[redacted], which violates Code section 2234.

10. Further grounds exist for revocation or other discipline of respondent's license in that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by failing to recognize and appropriately act on probable adverse drug reactions experienced by his patients, as alleged in paragraphs 5(A)(12), (13), and (14) regarding B[redacted] M[redacted], 5(B)(19) and (20) regarding L[redacted] W[redacted], 5(C)(11) and (12) regarding M[redacted] S[redacted], 5(E)(8) and (9) regarding L[redacted] H[redacted] and 5(F)(7) and (8) regarding G[redacted] H[redacted], which violates Code section 2234.

11. Further grounds exist for revocation or other discipline of respondent's license in that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by starting hormone and/or other dangerous drug therapy of his patients without adequate medical history, adequate physical examination or the results of diagnostic laboratory tests, as alleged in paragraphs 5(A)(7) regarding B[redacted] M[redacted], 5(B)(7) regarding L[redacted] W[redacted], 5(C)(6) regarding M[redacted] S[redacted], 5(E)(6) regarding L[redacted] H[redacted] and 5(F)(4) and (5) regarding G[redacted] H[redacted], which violates Code section 2234.

12. Further grounds exist for revocation or other discipline of respondent's license in that respondent repeatedly excessively prescribed or administered drugs or treatment, as alleged in paragraphs 5(A)(9), (10), and (11) regarding

B[redacted] M[redacted] 5(B)(9, (10), (12), (13), (14), (15), and (18) regarding L[redacted] W[redacted] and 5(C)(8) and (11) regarding M[redacted] S[redacted], which violates Code section 725.

13. Further grounds exist for revocation or other discipline of respondent's license in that respondent committed repeated acts of clearly excessive use of diagnostic procedures, as alleged in paragraphs 5(A)(8) regarding B[redacted] M[redacted], 5(B)(8) regarding L[redacted] W[redacted], 5(C)(7) regarding M[redacted] S[redacted], and 5(D)(6) regarding C[redacted] F[redacted], which violates Code section 725.

14. Further grounds exist for revocation or other discipline of respondent's license in that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by improperly delegating his medical responsibilities to others, as alleged in paragraphs 5(A)(5), (7), and (8) regarding B[redacted] M[redacted], 5(B)(5), (7), and (19) regarding L[redacted] W[redacted], 5(C)(6) regarding M[redacted] S[redacted], 5(E)(6) regarding L[redacted] H[redacted], and 5(F)(8) regarding G[redacted] H[redacted].

15. Further grounds exist for revocation or other discipline of respondent's license with respect to his treatment of B[redacted] M[redacted] as follows:

A. In that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by prescribing and administering dangerous drugs to Mrs. M[redacted] with no adequate medical indication to do so, as alleged in paragraphs 5(A)(10) and (11), which violates Code section 2234;

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B. By being unavailable to Ms. M[redacted] in an emergency and not providing for another physician to cover for him, which violates Code section 2234.

16. Further grounds exist for revocation or other discipline of respondent's license with respect to his treatment of L[redacted] W[redacted] as follows:

A. In that respondent committed gross negligence and/or demonstrated incompetence by prescribing, administering or dispensing to L[redacted] W[redacted] a combination of Maxzide and K-lyte, as alleged in paragraph 5(B)(11), which violates Code section 2234;

B. In that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by diagnosing L[redacted] W[redacted] as both hypoglycemic and hypoestrogenemic with no medical indication for those diagnoses, as alleged in paragraphs 5(B)(16) and (17), respectively, which violates Code section 2234;

C. In that respondent prescribed a controlled substance, Xanax, to L[redacted] W[redacted] in quantity and for a length of time that was not reasonably necessary, as alleged in paragraphs 5(B)(12) and (13), which violates California Health and Safety Code section 11210.

17. Further grounds exist for revocation or other discipline of respondent's license with respect to his treatment of G[redacted] H[redacted] in that respondent committed gross negligence or repeated negligent acts and/or demonstrated incompetence by his behavior regarding his patient G[redacted] H[redacted] from approximately August 8, 1989 until she terminated as his patient approximately

patient approximately the middle of September, 1989, as alleged in paragraph 5(F)(9), (10), (11), (12), and (13), which violates Code section 2234.

FACTS CONCERNING FALSE OR MISLEADING STATEMENTS UNDER CODE SECTION 17500

18. Respondent is further subject to disciplinary action pursuant to Code section 17500 for false or misleading statements in that on or about October 3, 1989, at 23021 Lake Center Drive, El Toro, California, respondent delivered a public lecture on the subject of hormone replacement therapy and other related hormone problems in which he made the following false or misleading statements:

A. Between the ages of 32 and 37 most females start losing their hormones;

B. That a person's estrogen and testosterone make their own gamma globulin;

C. That testosterone must go up 200 to 600 times normal in order to sustain a pregnancy;

D. That there is a relationship between the number of pregnancies and the frequency of them and ovarian failure;

E. That the average woman, after tubal ligation, loses 40 to 60 percent of her blood supply to the ovaries;

F. The suggestion that tonsillitis or scarlet fever are likely to reduce or destroy ovarian functions;

G. That painful menstrual periods are a sign of weakened estrogen level;

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H. That when estrogen in the female or testosterone in the male decline then the thyroid level is also pulled down;

I. The suggestion that the humane immune system can be boosted by sex hormones;

J. That hormone replacement therapy can help restore or improve hearing;

K. That 80% of the women that die in the United States each year from breast cancer would not have to die if they had natural progesterone and natural estrogen;

L. The suggestion that gamma globulin is used in medicine today in the treatment of infectious mononucleosis and measles in the first trimester of pregnancy;

M. The suggestion that a woman feels her best during a normal pregnancy and that this is due to the increase of hormones that accompany pregnancy;

N. The suggestion that because male gonads are "down in a tunnel" that the only infection that can get through is a virus;

O. The suggestion that low estrogen and progesterone cause fibrocystic disease of the breast and ovaries;

19. Further grounds exist for revocation or other discipline of respondent's license in that his treatment of patients by hormone injections and prescriptions before he has test results on their hormone levels, his excessive use of diagnostic procedures, his excessive use of hormone injection treatments, and his false and misleading advertising designed to promote business for himself show a pattern of dishonest and/or

corrupt acts substantially related to the qualifications, functions or duties of a physician or surgeon, which constitutes repeated violations of Code section 2234(e).

WHEREFORE, complainant requests that a hearing be held on the matters alleged herein and that following that hearing the Division issue a decision revoking Physician's and Surgeon's Certificate No. G6248, heretofore issued to respondent, Norman King Beals, M.D. and, taking such other and further action as the Division deems necessary and proper.

Dated: Nov. 13, 1989

Susan Fitzgerald for/
KEN WAGSTAFF
Executive Director
Division of Medical Quality
Board of Medical Quality Assurance
Department of Consumer Affairs
State of California

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